



State of California—Health and Human Services Agency
Department of Health Services



GRAY DAVIS
Governor

August 21, 2003

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Index: Eligibility

TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS)
ADMINISTRATORS, MEDICAL CONSULTANTS, STATE CHILDREN'S
MEDICAL SERVICES (CMS) BRANCH STAFF AND REGIONAL OFFICE
STAFF

SUBJECT: IMPLEMENTATION OF ASSEMBLY BILL (AB) 495; EXPANSION OF
CHILDREN'S HEALTH INSURANCE COVERAGE

I. BACKGROUND:

AB 495, Chapter 468, Statutes of 2001, established the Children's Health Initiative Matching Fund to fund the provision of health insurance for uninsured children by county agencies, local initiative health plans, and county organized health systems (COHS). The provisions of AB 495 are being implemented by the Managed Risk Medical Insurance Board (MRMIB) in collaboration with the Department of Health Services (DHS). The legislation provides for local funds (e.g., Proposition 10 funds, Tobacco Settlement funds) to be used to match, federal Title XXI State Children's Health Insurance Program (SCHIP) funds currently available to California. These health plans will provide coverage to low-income children who do not qualify for health care benefits through the Healthy Families (HF) Program or Medi-Cal.

AB 495 contains a service "carve-out" for enrollees who meet current California Children's Services (CCS) eligibility requirements set forth in the Health and Safety Code (H&SC) Sections 123800 et seq. and California Code of Regulations, title 22, section 41508 et seq. Children enrolled in one of the AB 495 health plans are not enrolled in HF, i.e., **AB 495 does not expand HF. The legislation establishes an entirely separate program. It does not change the existing eligibility requirements of the CCS Program, CCS State county cost sharing provisions for CCS services, or provide new funding for the CCS Program.**



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Some counties have already implemented enrollment of the expanded population into an existing health plan. Other counties have expressed interest in this process, but have not yet initiated enrollment of children. MRMIB is preparing amendments to the California Title XXI SCHIP State Plan for submission to the Centers for Medicare and Medicaid Services in order to obtain federal financial participation (FFP) for this new population. The AB 495 plans will use the Health-e-Application to determine prospective enrollees to be ineligible for both Medi-Cal and HF before enrolling them in the plan. For purposes of this letter these AB 495 plans shall be hereinafter be known as the Plan or Plans.

County CCS programs are being asked by Plans already in existence to authorize services for enrollees that they believe are CCS eligible. This letter is to provide guidance for the authorization of services for children enrolled in a Plan who may have a CCS eligible condition. This guidance applies to Plans that are currently in existence and Plans that will be implemented in the future.

II. POLICY:

- A. Each referral of a child from a Plan must be reviewed for CCS medical, financial and residential eligibility. The child must meet all three eligibility requirements.
- B. Children referred by a Plan and found to be eligible for CCS shall not be referred to Medi-Cal, pursuant to H&SC Section 123995, because they have already been determined not to be eligible for Medi-Cal.
- C. Upon determination of CCS eligibility, medically necessary services shall be authorized to CCS paneled and or approved providers, in accordance with CCS Program policies and procedures.
- D. Costs for services authorized for a CCS eligible child enrolled in a Plan will be shared 50 percent by the State and 50 percent by the county CCS Program pursuant to the provisions of H&SC Section 123940.

III. POLICY IMPLEMENTATION:

- A. The referral of a child to CCS from a local initiative or County Organized Health Systems (COHS) that operates a Plan shall be reviewed to determine whether the child is enrolled in HF or Medi-Cal. If eligibility in either of these programs cannot be confirmed, the CCS Program shall contact the health plan CCS liaison to determine if the child is enrolled in a Plan.

- B. If enrollment in a Plan is confirmed, financial, residential, and medical eligibility determinations must be performed. Unlike HF enrollees, Plan participants with a CCS Program eligible medical condition, but whose families are financially ineligible for CCS, are **not** “deemed” financially eligible.
- C. If the child is determined to meet all three CCS eligibility requirements and the child’s parent or legal guardian signs the Program Services Agreement (PSA), medically necessary services shall be authorized for the child.
- D. For purposes of adjudication of claims for the provision of CCS authorized services to a child enrolled in a Plan, the CCS Program shall not consider the child’s Plan coverage to be “other health coverage.”

IV. DISCUSSION:

Questions will arise as county CCS programs begin to implement partnerships with Plans. Because of differences between Plans, (e.g., some are enrolling children from families with income of up to 300 percent of the Federal Income Guidelines (FIG) while others are enrolling children from families with incomes of up to 400 percent of FIG), it is suggested that county specific policies and procedures be developed in collaboration with the Plan that operates in the county. This will assure that children are provided appropriate and expedient services and that provider claims are paid on a timely basis.

A county CCS Program can elect to provide case management and authorization of and payment for medically necessary services for children enrolled in the Plans who are not financially eligible for CCS; however, the cost will be borne by the County alone. AB 495 did not give the State the authority to share in the cost of Providing CCS services to Plan children **unless** they meet all three CCS eligibility criteria. (Insurance Code § 12699.53(c)). If a county elects to provide such services to CCS ineligible Plan children, it must follow the instructions below:

- CCS ineligible children enrolled in Plans **shall not** be entered into the Children’s Medical Services Network (CMS Net) automated case management system for eligibility tracking and case management;
- A provider authorization of service for these children **shall not** indicate by any means that the authorization is a “CCS service authorization.” CCS has no statutory authority to reimburse providers for services supplied to CCS ineligible children;

- The county **shall** have a system for direct reimbursement of provider claims for services authorized by the county for CCS ineligible children enrolled in the Plans. Counties **shall not** forward provider claims to the State fiscal Intermediary for adjudication; and
- Costs associated with resources (e.g. county staff, operating expenses) required for case management and ancillary services provided to these children **shall not** be budgeted in the county Children's Medical Services plan and budget and **shall not** be reported for State financial participation on the county CCS Quarterly Administrative Expenditure Invoice.

Local CCS administrators in counties which are considering the expansion of the county local initiative or COHS to cover additional children pursuant to AB 495 should carefully familiarize themselves with the provisions of this legislation. For further consultation, please contact your Regional Office Consultant.

Original Signed by Maridee Gregory, M.D.

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